Information Exchange Workgroup Provider Directory Taskforce
Draft Transcript
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Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Provider Directory Taskforce, which is a subset of the Information Exchange Workgroup. This is a Federal Advisory Committee so there will be opportunity at the end of the call for the public to make comments. Just a reminder for workgroup members to please identify yourselves when speaking.

Let me do a quick roll call. Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Peter DeVault is in for Judy Faulkner.

Peter DeVault – Epic Systems – Project Manager
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Seth Foldy? Jim Golden? Dave Goetz?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Hunt Blair?

Hunt Blair – OVHA – Deputy Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson? George Oestreich? Sorin Davis?

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Keith Hess? Sid Thornton?

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Lisa Robbins?

Jonathan Jagoda
This is Jonathan Jagoda. I'm here on Lisa's behalf.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Jonathan. JP Little? Kory Mertz?

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Claudia is joining a little late. So with that, I'll turn it over to Jonah and Walter.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Walter, I'm going to turn it over to you because I'm in a busy place and it's a little loud here. So ....

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay. Thanks, Jonah. Thank you, everyone for joining this morning. We're going to be focusing this morning on continuing our work on the individual level provider directory. We have prepared some materials to discuss with the group. We have available in some more detail the use cases that we think describe the functionality and some of the characteristics of this individual level provider directory. Then we'll be talking about some of the business models.

I think we wanted to start on the agenda—and maybe if we go to the next slide on the presentation—we wanted to start, and I'm going to switch the first slide. We want to start first with a very brief description of the presentation that we did to the Health IT Standards Committee on the entity level provider directory recommendations that this taskforce put together and that were approved by the Information Exchange Workgroup and then endorsed by the Policy Committee. So I'll just make a few brief remarks about that session. Then we'll dive into the discussion of the individual level provider directory. As I mentioned, we'll be talking about assumptions, a description of use cases functionality, and some of the initial thoughts about the content and operating requirements. All of this is basically a first step in refining the

conceptual base for this individual level provider directory. So I hope we'll have a very rich discussion on all these items.

Let me start with a very brief set of remarks on the presentation to the Health IT Standards Committee. The Health IT Standards Committee met last week and one of the items in their agenda was a presentation from our group, the Provider Directory Taskforce, on the recommendations that we put forth on the entity level provider directory. So we had Micky and Jonah and myself and a few other members present and were able to introduce this context of provider directory, first of all, and then discuss entity level provider directory and the recommendations. And talk about the specific recommendations for action by the Health IT Standards Committee in terms of identifying and developing recommended standards for entity level provider directories within the context of the policy parameters that we set in the recommendations.

It was a very good, good review and a very good discussion of the basic concepts. I think it was clear, number one, that this is something very important and valuable to do from the perspective of the HIEs and from the perspective of the views by the industry, in general, and so I think it was generally well received. Conceptually, I think there were a number of questions around who's going to be in these provider directories and how the provider directory is going to operate itself. As you'll all recall, we recommended a series of policy directives on organizing this provider directory and setting up a series of certified registers and a registry system that will be used by entities to access entity level information and discover a number of important exchange elements about those entities. Including where their security credentials are and what are some of the information exchange characteristics of those entities, what are the messages that they support and receive and are capable of accepting and exchanging.

I think there were a couple of questions about the business side and who is going to organize all of this or how much is this going to cost, and I think we mentioned that during our deliberation we really didn't get into the details of cost of sale of doing this work. I think a number of cost items have already been incurred in the industry by virtue of what people are today doing in trying to identify entities and trying to look into what kind of capabilities they have to receive messages and exchange messages and how each of the HIEs around the country are having to look into doing this. But we didn't really quantify, if you will, exactly the cost, so that was one of the questions that the Standards Committee representatives had, and I think that's something we should probably go back and look into, particularly as we get into the next level of provider directories.

But generally speaking, I think that the next steps basically from the discussion were that the Standards Committee is going to be then taking on looking at elaborating basically those recommendations from the standards perspective and taking it to the next step and basically taking it to the next level of identifying and recommending standards. Essentially, there was the idea of two parts. One is the technical standards themselves and a group within the Standards Committee looking into that, and then operationalizing this provider directory and the distance aspects of those, and that was something that the Standards Committee was also going to get into. There was no decision yet of which of the groups within the Standards Committee would undertake those responsibilities.

There are two possible groups. One is the Standard Committee's Security and Privacy Workgroup that can certainly take on the work of the technical standards side of provider directory. Since that workgroup is going to be taking on the work also recommended by the Policy Committee on digital certificates, I think there's a natural opportunity to link the two and do work around the two. So that could be one of the workgroups that we'll be looking at elaborating on the standards side, the technical standards side for provider directory. There was a discussion then about who would be doing more of the business side, the operating side of the provider directory, and there were some ideas around perhaps a clinical operations workgroup doing it, but in the end, the committee didn't make a final decision about who would do that. The leadership of the committee will be getting together and making a determination about that. There was also some suggestion that maybe there's another group under the Standards Committee that needs to be created addressing this and other future aspects of information exchange standards. If it's not the

Standards Security and Privacy Workgroup itself then it could be a new workgroup within the Standards Committee that will be addressing information exchange standard issues and recommendations.

I think, again, the next step is going to be to have the Standards Committee make a decision of which of the groups will be addressing these recommendations and then having that group get on with the work of basically developing those recommendations, the standards outside of the provider directories. There was a clear sense of a need to continue a very dynamic, I guess, or interactive dialogue between the Policy Committee Information Exchange Workgroup and the Standards Committee as these standards are discussed for provider directories. Making sure that if there are any policy questions or considerations that weren't clear necessarily or the Standards Committee has questions about, that they can be addressed by the Policy Committee's Information Exchange Workgroup and the provider directory ....

I think that was basically the briefing on the committee discussion. I don't know if there's any comments, anybody else that attended that, and want to make any additional comments or anything that I missed. Or if there any questions about what the Standards Committee .... Jonah, I don't know if you want to add anything?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
No, that was great. We did do a very quick debrief at the HIE community meeting last week, so you've definitely covered it.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Great. Okay, so let's move on and get into the discussion of the individual level provider directory. We distributed these materials and so we're going to go through some of these slides and we're going to be stopping as we go along to discuss and to open up for any questions from the taskforce members.

A few of the next slides are, this one is actually about the report to the Standards Committee, so let's go to the next one. Some of these slides you will recognize. This, again, is a reminder that we will be using basically the same framework that we used in developing the recommendations on the … level provider directory to discuss and develop the recommendations in the individual level provider directory. So we'll be looking at those same requirements and options or components to users and users' functions, content, operating requirements and business models and then talk about policy recommendations.

This is a timeline that we have put forth and we're working towards that. Also the remainder of this month we will be actively engaged in developing recommendations around all these aspects of the provider directory, the individual level provider directory. Today we'll talk about the items I mentioned and we hope to, by next week, have some additional discussion and approval of the business model and discuss some of the policy issues. Then bring all those to the Information Exchange Workgroup's meeting on January 28th and take their endorsement and approval so they can be presented as recommendations to the Policy Committee in early February, so that's our work plan at the moment.

This was discussed and introduced at our last call of the taskforce a week or so ago and then this is primarily just highlighting some of the underlying assumptions and the framing for the development of the individual level provider directories. We talked about the scope of the ILPDs being sub-national. We talked about rigid conformance at the national level is not going to be necessary for these individual level provider directories. We also mentioned that the states are currently working towards or already implementing some type or some form of this provider directory. So we need to move fairly quickly to make sure that these recommendations can be then turned into the type of activities that the state will be doing and the information that we provide here will be able to be used by the states in furthering their HIE efforts. So we're focusing on best practices for establishing and maintaining these provider directories and looking at all the different aspects of these ILPDs, particularly the data accuracy aspect of it. We talked also about the best practices for local policy levers for incenting participation in ILPDs, so what's the ways that states and regional initiatives are using that and others are using to incent participants to

join and to use ILPDs. We also mentioned again that we would be basically using the same framework that we used for ELPDs to build the ILPD recommendations. Any questions, reactions, or comments on this one?

Okay, let's move to the next one. Again, this is a little bit of a review of items that were discussed on the last call. Some additional assumptions that we are refining basically, we see that the ILPDs would be providing enough information to, just like with the ELPD, enable resolution of certain information discovered and enable resolution of certain items, specifically the proper destination, the location of individuals and individual provider practices in looking at the proper destination for a message, for example. The ILPD would return multiple listings and then the requestor, based on information that they would have, would be able to choose and to select the appropriate .... So the ILPD would basically provide these locations of where individual providers practice and reside. The ILPDs would also have a relationship with the ELPDs so that when the location is identified of where a provider practice is, the information about that location that resides on the ELPD can be used for the secure exchange of messages. We'll talk a little bit more about those a little later.

Maintenance and updates to ILPDs would be managed at the local and regional level, and the primary value proposition really is in the exchange of clinical documents where there is some basic information that providers have about each other and about where the patient is seeking care and needs to locate their practice. There are some important assumptions around the fact that there is some basic information that is known about the providers that are exchanging data, but it's only some basic information, not all the detailed information is available, and that's what this ILPD would support. A lot of this I think will be able to be clarified harder as we get into the use cases in some of the next slides. Any questions or comments about this slide?

So let's move into the use cases. What we did in developing these use cases is we started looking at various scenarios in terms of the organizations that would be looking at exchanging messages and how they would need to use an individual level provider directory to identify certain elements in order to achieve the exchange. So we looked at clinic to clinic scenarios, hospital to clinic, lab to clinic, and we looked at a couple of other ideas and so we started to flesh that out. We also looked at both a query and retrieve as well as a request and send, if you will. So that's what we call a push and a pull scenario and we'll be going through those as we discuss the scenarios. In presenting these, what we wanted to isolate, if you will, and to try to specifically highlight, which is in the middle of this ... is the ILPD functionality, what is it that the ILPD will support in achieving this scenario.

Let me start with this first scenario, the clinic to clinic exchange and in a push scenario. So the exchange data is basically a PCP (a primary care provider) in a clinic X needs to send a clinic document about a patient to a specific individual provider who is a specialist in clinic Y. So that's the situation, a referral to a specialist situation. The submitter, in this case the PCP in clinic X, has some information about the specialist but does not know all of the details or specifically doesn't know the individual provider's location information. So the ILPD functionality that will help this exchange needs will be basically that the submitter, the PCP in clinic X, will use the ILPD to search for the specialist and then identify the various practices where the specialist practices. Based on information that that primary care provider had and the listing that the ILPD will provide of all the various places where the specialist practices, the PCP will be able to identify the appropriate location, so, here's an important assumption, that the ILPD itself is not going to tell which of all these locations is the right one. There will be some information that the submitter, in this case the primary care provider, will have to know or to use in order to select the appropriate location among those that have been listed in the ILPD for that particular specialist. That's an important assumption.

The ILPD then will associate the physical location that has been selected by the submitter among all those identified with the information for that location that exists in the ELPD. Then using the ILPD, the digital credentials of both the sending and receiving computer systems are going to be used to validate identifiers and be able to achieve a secure exchange. By doing that then the way that exchange is

achieved, basically clinic X's EHR will then be able to send the patient summary, let's say a CCD, to clinic Y's EHR. Then it's important that clinic Y's EHR will be receiving this information of a patient and will then put that information, receive it and then incorporate that information into the appropriate patient's EHR, into the appropriate patient's record in the whole EHR system. That connection will be done internally by the clinic's EHR, the EHR of the clinic that's receiving the message.

Additionally—and this is outside of the purpose and value of ILPDs, but additionally of course once the clinic Y's EHR—the clinic that received the message, once they receive the message and it's incorporated into the EHR's patient record, then that EHR system could have some sort of an alert mechanism, a mechanism to alert a specialist that new information about the patient has arrived, for example. Additional functionality beyond what the ILPD would support, but the opportunity is to alert in advance basically of new information. This will be more valuable of course in other situations like hospital events and others that we'll talk in just a minute about. Basically, that is a description of a use case in which the functionality of the ILPD will be used.

Let me stop there and see how people react to that description.

Peter DeVault – Epic Systems – Project Manager
My question is on the last item in the middle column. I'm not sure that I understand what's being validated and what credentials are being shared. Specifically because if we look at the third column, this looks very much like one of the use cases from the entity level provider directory and the individual level provider directory was sort of just used as an intermediary to figure out which entities should be exchanging the information. So could you clarify what actually is being credentialed and validated in the middle?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think the idea is that the provider directory, both the ELPD as well as the ILPD would have information about security certificates. They would not have the actual details of the certificate, but just enough information to allow entities to search and validate those certificates, whether it's a digital credential or whatever it might be.

Peter DeVault – Epic Systems – Project Manager
Yes, so that's what I'm confused about. It seems like the entity level directory needs certificates. I'm still confused about what the individual level directory would have relative to certificates.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Peter, I actually think that might be accurate, and maybe, Tim, if you're on the line you can help clarify, that we may want to restate that the last bullet should state ... on the ELPD ... credentials. I think that's more appropriate, but I want to make sure that Tim and others agree.

Tim Andrews
I sort of agree. I think that is unclear. I think the idea is that the ILPD has this association, as the point before says, with the ELPD. Presumably at this point 99 times out of 100 it would be the ELPD that would be doing, we aren't assuming that there would be any certificates at the individual level. So it's correct in both ways. It's probably clearer to say ELPD. An ILPD would get you to the ELPD, but the ELPD would contain the certificates that would actually be used.

Peter DeVault – Epic Systems – Project Manager
Perfect. That makes a lot of sense.

Paul Egerman – Software Entrepreneur
I had the same question. It does seem like the previous bullet where it says, "ILPD associates physical location was ELPD," I interpreted that to mean it's pointed to it. Once it's pointed to it, it seems like the

ELPD stuff just takes over. So that's helpful. The last bullet is a typo where it says "ILPD" and then "ELPD."

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, that's probably something that carries into the other use cases too. So we'll make sure we clean that up.

Paul Egerman – Software Entrepreneur
I'd like to actually go back to the previous column where you say you're trying to find the specialist location. When you say "location," I'm assuming that means when you find it, it means the specialist practices at clinic Y, right?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. The specialist could have multiple locations of course, so the specialist location has at least two characteristics in my mind. One is that is there one that the patient would like to go to, whether it's convenient or it's close by to them or the one they prefer to go to. Secondly is the one—and here's another element that will play into this—is the one that the patient also co-qualifies to go to, if you will, when you include the condition of coverage basically. So it is identifying the location where the specialist practices, but the location where the individual would want to go to and is qualified to go to.

Paul Egerman – Software Entrepreneur
So that could be, but as I read this case, this scenario the only thing you're trying to do is to get this document, the CCD document, in the hands to the other EHR system. So the only thing, according to this particular scenario, that you need is the identity of clinic Y, right?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes.

Paul Egerman – Software Entrepreneur
And if clinic Y happens to be, say, Kaiser or UPMC that's fine. You don't need to know what building the specialist practice is in or what floor or what campus in this scenario. There may be other scenarios where you need it, but all you need to do in this scenario is know this specialist practices at clinic Y. Am I missing something?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
No, no, that is the main purpose here. The primary care provider knows the name of this individual they want to refer this patient to. The only thing they need to know is where does this individual practice so they can send that information to that location. Because they might practice in Kaiser but they might also practice in some other organizations separate from Kaiser, for example, and so they need to know out of the two which of the two is the right one to send this information to.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
To that point then, so Dr. Smith works at practice A and practice B, and what you'd need to have is Dr. Smith, the two entries, Dr. Smith practice A, and Dr. Smith practice B, each of which is linked to a different ELPD, so that it went to the right entity for that setting, right? So it's the doctor works at Kaiser but he moonlights with some emergency department somewhere, so he's got two different locations. They're two different EMRs altogether. So you really just need to make sure it's getting to the right EMR, which is an ELPD thing, but the ILPD has to designate that that person has two valid options for an ELPD landing point.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that is right. The ILPD would have to show that there are two valid location options and each of the two will have a separate ELPD link.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
But the location though is less important to physical location. It's important to only the EMR location, so essentially there needs to be enough information to identify where you're sending it to, but the where digitally is just which ELPD is going to receive the hand-off.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, although one could imagine that clinic Y does not have, in this scenario in column three, the second bullet, we're assuming that in clinic Y the patient that is being referred already has some record there and this new information that the primary care provider is sending is going to be incorporated into that EHR. So there could be other situations in which the patient does not have any record yet in clinic Y. It's going to be the first time they're going to see this patient as a specialist.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
That will happen with some frequency actually because the primary care physician would refer to a specialist, and the specialist has probably never seen that patient. But that would be a whole different problem, wouldn't it, that what do you do when you receive a CCD for a patient that's not established there. And that would have to be something at the—

Peter DeVault – Epic Systems – Project Manager
I think that problem's out of scope for the directory discussion.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Exactly.

Peter DeVault – Epic Systems – Project Manager
One thing I think we need to be careful of, because in one sense, from a technical sense it's correct to say that all we need from the individual directory is to find out which EHR to send it to, that is, which entity it belongs to. But we shouldn't assume that the person looking up the provider has inside knowledge about which locations are on which EHR. That is to say, if what they're trying to do is distinguish between several Dr. Smiths based on things like their specialty and what address the clinic is at, that address might actually be important. So although we don't technically need the clinic addresses that Dr. Smith works at, that might be the kind of information that's necessary for the person looking up the provider to disambiguate between those different locations, even though the different locations might all be on the same EMR.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think this is a point we had a little e-mail discussion about this weekend. It does seem like that disambiguation stuff is a really critical one. We're hopeful that precise location information, geographic, can be a critical piece in saying, A) I think this is the right doctor because this pattern maps what I believe to be the pattern for that doc, if there are two John Smiths who are PCPs in the state I want to identify the right one. And B) but in fact we may need to revisit that it may be that we need MPI or something else that's much more definitively able to disambiguate that we have the right one identified. Then the second of course is which location needs this information. Is it the PCP office or the hospital office? And we're also concerned, it's the same doc but we want to send it to a place where it will be useful and they might be using different EHRs in those different locations. I agree that the geographic location information is critical for both and that we can't assume that the same EHR is used in both settings. That seems very smart.

Peter DeVault – Epic Systems – Project Manager
Yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, so the two characteristics is identifying the right doctor, first of all. Then identifying the right entity for that right doctor, and entity meaning location that we're pointing that it's not necessarily— When we say location specifically, it's not necessarily what we mean that we need exactly the address or we need to first know which is the right entity, is it Kaiser or is it someone else? In some scenarios we might actually not need to know exactly a location as in any particular address, so I think it's important to clarify that point, I guess.

M
We're going to have a bit of a discussion about the ... recommended content for ILPDs. I think when we revisit that we may want to make some decisions about whether and how we would get the kind of information we're talking about here.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So we can move to the next scenario. The next scenario will reemphasize some of these points that we have discussed, so let's go to the next slide. The next slide shows basically a pull scenario. It's similar to the previous one except that in this case the specialist in clinic Y is looking for information about a patient and is looking for a document from a primary care provider in clinic X, so sort of the reverse of the previous scenario. The specialist has some information about the primary care provider but does not know exactly the location. So in this case again the functionality of the ILPD will be to support the look up of potential locations. First of all, we're saying look up of the right primary care provider, the individual provider, and then look up the right location or entity for that primary care provider. So the ILPD will provide that listing, the specialist will select the right doctor and select the right entity, and send a query or a request for information about the patient that they're looking for. As in the previous scenario, the ILPD will associate this link, provide a link to this location and this entity on the ELPD address. Again here creating the typo using the ELPD, the doctor's credentials, will be used to ensure the exchange happens.

So in the final column the achieving of the exchange, clinic Y will send a request for the summary records. Then the clinic X EHR will receive the request, validate the information about the request and about the sender. Then send back the summary record to clinic Y, who will then receive it and incorporate that into their EHR and then in this case the last bullet just points to an additional functionality opportunity for the EHR itself to alert the specialist that new information about a patient has arrived.

Continuing all the discussion we had in the previous slide and sort of adding those elements into this one, are there any other elements for this whole scenario that we need to clarify?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Just one thing, in this instance where you're pulling data, there's kind of a check on the accuracy. Because if you identify the wrong Dr. Smith when you put in the patient information, and I don't know what data fields are necessary to get a secure ID ..., if you've identified the wrong Dr. Smith the likelihood of them having any records on that patient Y is unlikely. So in this case it's more forgiving, I guess, because you actually have two different key data things that you're going to submit to try to pull data. So, just the observation that this one is a more forgiving approach since you have to do both the patient and the doctor.

Paul Egerman – Software Entrepreneur
That's a good observation. I had two observations about this scenario. One is, this pull scenario is not one of the transactions in Meaningful Use yet, so that's just one comment. The second one relates to the last comment, is in a pull scenario. If we want to write this up and speculate how a pull scenario would work, we've got to put the word "privacy" someplace in achieving exchange. Because you don't want to have a situation where you have this image where a specialist can just request information from primary care providers until they find it, they just go through 200 primary care providers until they find the right one where that patient is, and then get .... There has to be some reason the specialist has a relationship with the patient.

M
Maybe we should just annotate these use cases to point out that that's out of scope for the provider directories. Not that we hadn't thought about it, but that that's something that the provider directories go to ... for.

Paul Egerman – Software Entrepreneur
Yes, somewhere you've got to have some statement, or maybe put it in at the beginning that this is all subject to both federal and local privacy rules, because otherwise I read this and I put my privacy hat on and it's like all kinds of red lights go off. I think we need someplace there's a preamble or something.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
With the sensitivity of the privacy issue, I think we should probably put it in bullets. We should probably make a point at the outset of the scenarios covering the privacy aspect. Then in this particular pull scenario we should also make a notation about the importance of privacy in ensuring that the appropriate laws are complied with and the appropriate ... on consent and established relationships with a patient are confirmed.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
The conversation, they think there might be a best practice drawing from the pull example where if there's remaining, let's say you've identified a doc and you think it's the right one, you could send a message simply saying I have some information relating to this patient, are they your patient? So from a push standpoint there could be different models, one of which could be a simple confirmation back and forth before you send a patient's data.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I would say that that could be a very useful functionality and I can certainly think of instances where that would be helpful. I think, just like all politics is local the vast majority of healthcare is local, though, and I think for the day in and day out scenario, that would probably capture nine out of ten or more encounters, the doctors will actually know the individual.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes, right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So it's useful but it's a very small subset, I think.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think your point is a very good one, that we shouldn't be designing for the exceptional cases but we should make explicit our assumptions.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Correct.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay. Any other comments on this scenario? We'll make those notations and we will mention also, Paul, as you point out, that particularly these pull scenarios are not necessarily scenarios requiring in the current Meaningful Use, but certainly are scenarios that the ILPD could support and scenarios that could be happening.

Paul Egerman – Software Entrepreneur
It's okay to do it. I just want to make sure that we all are looking at this ....

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Okay, let's go to the third scenario. The third scenario in the next slide is the exchange of hospital data to clinic scenario. Actually this is a fairly common one and effectively a fairly valuable one as well. The scenario basically is a hospital sending a patient document, whether it's a summary of discharge or ED report or surgical report, or recording a utilization event, the fact that a patient has been admitted, for example, to the hospital in advance before the patient has been treated and discharged, just an alert to the patient's primary care provider. So the exchange need is a hospital sending that information to the primary care provider where the patient's record is.

Again, the hospital has some information about the individual provider but does not have the location information. So the hospital will use the ILPD to look up, again, potential locations of this primary care provider and the ILPD will provide this listing that the hospital will identify the correct location and then the connection will happen again with the ELPD and the ELPD will provide the digital security credentials. So it's very much a similar functionality as we've been discussing in the previous scenarios. Then the achieving of the exchange will happen, the hospital discharge summary will be then sent to the primary care provider, or again the utilization of another event, where the primary care provider practices and the patient record resides and that clinic EHR in clinic X will receive the hospital report, incorporate the data. Again, there is that additional possible functionality that the EHR will have a feature to send an alert to the primary care provider that there's new information about patient X, whether it's an alert that the patient has been admitted to the hospital or whether it's a copy of a discharge summary or an ED report. That's the functionality for a hospital to clinic exchange. Any reaction to this scenario?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is an unusual experience for me to have the opportunity to speak so much on one of these calls. In the bottom right corner, the last thing you just mentioned, I was laughing out loud. I was going to say it's aspirational, as if all of this isn't a little bit aspirational, but that last feature about automated alerts I would say almost is the one that doesn't fit on the page. It may be useful. It may be something that we want down the road. But I think that the principal focus at this stage really should just be when one human professional makes the discrete choice that I want to send or receive this information between another individual, as opposed to leaping to the automated part at this point. Because I think there are a lot of other implications that go with that.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That's a good point. I think Claudia caught that point as well. Yes, I think that is something that is not directly relevant to the ILPD itself. So it was just additional features, if you will, of a possible EHR alert. But we can take it out, definitely.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I would agree with that, except when we get to the public health discussion, and maybe that's where we can ask our public health colleagues to talk about how urgent this is, because there I think there's some really low-hanging fruit around syndromic kinds of alerts. But we can hold that off until we get to that section.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Claudia, I think this is an alert about an alert, if you will.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So the alert on the public health scenario, as we'll mention in a minute, will still be an alert message back to the provider. The question I guess is really the workflow inside EHR and whether that EHR has that additional feature of alert that an alert has come in, or something like that. I think what we'll do is clean out this last ..., with eliminating the last bullet to make sure that there's no confusion about what's the relationship of this extra feature to the ILPD, because there isn't any ....

M
And you've already covered this. I'd just say it's not that it's not important. It's absolutely important. It's so important that it probably is deserving of its own multiple slides or discussion, I guess, so that's why I'd remove it from here.

Paul Egerman – Software Entrepreneur
Yes, I agree. Most of the EHR systems have some inbox or something that a PCP has to sign off on pretty much all the changes to the record.

M
Yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I just wanted to mention, this scenario is—of course as are the other ones, but this one especially—is a real scenario in today's HIE world in which states moving to establishing the HIEs or are already working in implementing HIE. Certainly the ability for hospitals to let primary care providers know that patients are in their care at this point, alerting them about that and/or after discharge sending electronically summary records and reports is something that is really a very important one for these HIEs, I think. I think all of us in the industry are dealing with that specifically, and the value of it, I think, is going to be .... Anyway, any other comments on this scenario?

Okay, let's go to the next one. The fourth scenario is a lab to clinic scenario, so in the next slide—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I didn't look at these before the talk today, but one that's between these two is actually the pull scenario for the hospital setting that you just touched on. So maybe it was covered in the preceding discussion but a very important scenario is the patient comes to a hospital, the hospital has no records on the patient and they need to get those records. Now, you could modify that first one, which was doctor to doctor in the pull scenario, but certainly in the acute care setting being able to pull records if they weren't pushed to you is invaluable. So that may be worthy of its own slide, which will be a modification of the other pull scenario.

Paul Egerman – Software Entrepreneur
That's a good comment. ... that like an ED, an emergency department requesting information. Then this becomes less troubling from a privacy standpoint and it becomes, well, this makes sense, they're trying to get information and they have a good reason for doing it.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
It's interesting. Actually when we developed these scenarios we had, actually we have more slides on scenarios than what we're showing you. We just thought we weren't going to be able to cover all of them during the call, so we wanted to focus on a few of them. But yes, I think Jonah was the one, and Tim, developed a slide already with that particular scenario of a patient showing up on an ED and the hospital searching for information about that patient and looking for not just all the providers but all the places where information might be. So yes, that is another scenario that we already have and—

Tim Andrews
The original use case, even on the specialist side, was narrower and more along the lines of somebody shows up at a specialist's office but for whatever reason the referral consult note isn't there. The summary didn't get there before the patient did, or at least before whoever is setting up for the patient's arrival looked for it. That's where this pull scenario ... makes a lot more sense. You've got a patient arriving or the patient's already there, but somehow or other the records didn't get there, and this happens quite a bit, as you know. So that was really driving the clinic to clinic specialist pull scenario and then the ED scenario is for the obvious one on the hospital side, or the pull scenario as well. So that's

where you started out from and we can try to make that more explicit that these are intended to start out as fairly narrow use cases where there's an urgent need for information and that's why you're trying to do this pull thing.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I'd like to dwell on this just one more second, and the reason why I think it is worthy of pulling it up to this level and including a separate slide is, one of the key aspirations or hopes, I think, for Health Information Exchange is the potential not only for improved quality but for cost savings. So in both patient safety and cost savings it is a common occurrence, I'm an emergency physician, so it's a common occurrence where a patient has surgery at hospital A, goes to hospital B because it's a five minute shorter drive for their postop complication two days later. Or they have heart failure and cancer and their doctors are at two different hospitals and so they show up for a cancer related complication where their cancer doctor is, but in fact they have acute heart problems at the same time. So the need to get that information where you can pull it in the acute care setting, that will get at those high cost beneficiaries with a much higher likelihood than in the outpatient office setting, although that's still very, very important.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thanks, Steve. We will include that additional scenario and document it as well to show the value of the provider directory in a pull scenario for hospitals. Let's go to the next use case, which is a clinic lab to clinic exchange.

In this case, the situation is that a clinic lab is going to be sending results about a patient to the ordering provider of that lab as well as other possible members of the care team again consistent with CLIA requirements, laboratory regulations that controls disclosed releases of lab results. So that exchange needed a clinical lab who knows of course the individual provider who ordered the test but does not know the locations and doesn't know other information about other members of the care team. So the clinical lab uses the ILPD to obtain the information needed about the ordering provider and the other recipients, and the ILPD will return locations, return addresses, and potential other relevant information about the ordering provider, and the other possible recipients of the results. The clinical lab conducts CLIA verification, the validation basically consisting of the CLIA requirements of the recipients, and may use the information they gathered from the ILPD regarding elements about individuals to conduct verification, and again, here, using the ELPD, not the ILPD. The ELPD ... certification, credentials are exchanged.

So achieving exchange, the lab results are then sent from the clinical lab to the ordering provider. The ordering provider's EHR system receives the lab and incorporates that into the patient's record. Again, we've kept this alert but will eliminate that as well. This is the additional functionality that I've been mentioning that we'll take it out of this scenario to avoid any confusion. So that's the last scenario, and the use of the ILPD to support that exchange.

Any comments or reactions?

Paul Egerman – Software Entrepreneur
I'm a little bit surprised by this. Has this ever happened? I would imagine a lab, because I know the ordering physician also knows the entity and the location also and if it's electronics then they've got probably an electronic order, so is this a realistic scenario, is I guess what I'm asking? I'm a bit surprised by it.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I guess it is sort of. Again, I could think of a myriad of examples, but in the emergency department, it may be that I know your primary care doctor and you need a gallbladder ultrasound but you don't need it at 11:00 at night and it's not eligible for an emergency setting, and so I write you a prescription that says "Outpatient gallbladder ultrasound. Results to Dr. X." The patient goes the next day, gets an outpatient gallbladder ultrasound and the results now need to be sent somewhere. That's a radiology study, but laboratory could be similar, where you call the primary care doctor and they say, could you just get a

hepatitis or a liver panel or something that won't come back in the emergency department setting and we need the results. You might send them an outpatient lab order to get it done the next day.

Peter DeVault – Epic Systems – Project Manager
I think that's exactly right, that a scenario occurs when there isn't a full electronic loop. So some days the scenario might go away when everything's electronic, but it does happen often that you don't know where the patient's going to end up, either you don't know where it's going to get results or you don't know when it's going to get results. So there's a paper process in the middle that results in the agency not necessarily having that tight knowledge of where to send it back to.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Thanks. I understand that now.

Tim Andrews
I would add, I don't know if it will happen but part of the potential here is that the labs themselves might be interested in getting out of the business of maintaining ILPDs themselves, which they have to do now and which is quite expensive. So it wouldn't be in the direct workflow of a particular care encounter but it would be in the workflow of the lab flowing through the verification process where they'll get a request to sign up provider X and they've got information about provider X. Normally they go through a process of collecting the rest of the information needed and finding the connection points and verifying them, and that could be potentially simplified and the cost reduced quite a bit ... cost effective. It's not clear and we'd have to have some more discussions with the labs about how willing they would be to do that, but in informal discussions, they were interested.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay. We might need to add some more clarification, because your question, Paul, might be a question that a lot of people might not necessarily be familiar with how some of this work happens—

Paul Egerman – Software Entrepreneur
Well, the scenarios you described were very helpful, because when I first read this I pictured a high volume chemistry lab and they pick up the samples, they do the work, the results come back, and it's pretty routine. The examples were great. You might want to choose one of those on the exchange need and elaborate a little bit, although maybe I'm the only one who viewed it that way.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think it will be helpful to, so we'll do that. Then the next slide I think just highlights a couple of other areas where use cases and value of ILPDs can be highlighted. So the public health alert is one. We did have actually a slide with a scenario describing that, and we can bring it back up. We wanted to just present today just a few examples. But there are a number of other situations and examples that one can think of. The public health alert is basically a public health agency needs to send an alert to a selected group of individual providers about a particular public health event or a situation. The public health agency was using ILPD to identify the individual providers, their locations, and then we'll be able to send the alert to that group of providers. We point out that ILPD will need to provide some flexible querying capability to allow the agency, the public health agency, in this case, to identify the providers for various types of alerts, whether it's a communicable disease situation or some bioterrorism situation or some other various different types of public health alerts that different individuals might be the recipient of those.

That's a quick example of public health alerts. Again, we'll be able to create a full-blown slide to describe it. I think it's going to be very important to do that and particularly in light of our members in our workgroup having so much experience with public health and information exchange and I think it will be helpful to have a full-fledged description of how public health will be able to use these ILPDs.

Then the last one is provider credentials, so here we thought, Tim mentioned in one of our exchanges during the last few days the possibility of supporting administrative functions with the site of provider directories, and one example was provider credentials. Every provider has to be credentialed by different institutions, whether it's a health plan, to be part of the health plan provider network or a hospital to receive hospital privileges, and so everybody needs information to gather information about individuals and individual providers' credentials. So the ILPD could provide some of that basic information about the individual provider, location of the provider credentials, etc., and then the entity will be able to validate those through their full-fledged credentialing process. So that was one additional possible use of ILPDs above and beyond ... exchanges.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
. I think that that provider credentialing scenario you just described is probably in present day reality the least likely useful scenario. They have to do primary source verification on all sorts of stuff, so other than just getting a quick idea about something, it really wouldn't save them all that much effort.

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)
Just to second what was just said, not only do you need primary source verification, but you would be increasing the data set required with individual level provider directory by an awful lot. There are third party creditors involved in this that are pretty prescriptive as to what the data collected is and then you also get into the timeliness issue of the data, because you now have to maintain a clock on that information as well for it to be useful for credentialing. If it exceeds a certain amount of time, it's not valid anymore.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I'd almost suggest we remove that. If you program this in XML with metadata tagged elements according to PCAST, apparently it can evolve into whatever we want it to down the road.

Paul Egerman – Software Entrepreneur
Steve, I 100% agree with the last comment. But I also agree with all the comments about provider credentials. If you think about the credentialing function it's not information exchange, it's a different function altogether.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, this was really more of a look up, and as has been pointed out, it's the least likely useful application for the ILPDs, because at the end, absolutely, of course the full-fledged credentialing process with primary source verification and all this will still have to happen of course. The intent wasn't to really use the ILPD to skip that process or anything like that. So point well taken and we'll concentrate on the other use cases and try and expand some of the other use cases and skip this particular one.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Walter, for the public health alert, you've got the direction going one way there and I know that there are other possibilities, but one of the, I would think, largest promises or hopes for public health is actually syndromic surveillance. So to the extent that, say, acute care hospitals or doctors' office EMRs could auto report de-identified data just only on ICD-9 codes. So if you see a sudden spike in diarrhea illnesses in a certain set of zip codes or you see a spike in respiratory or influenza-like illness diagnoses, syndromic surveillance data, even if it is limited only to certain key diagnosis codes with no other information, that could be very useful for public health doing community surveillance.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Absolutely. Absolutely. Clearly syndromic surveillance is actually one of the Meaningful Use elements. How do you see the ILPD supporting that? We were thinking, okay, so public health needs to identify providers to send data, so in the bidirectional communication, the communication going back, the providers sending data to public health, say, on syndromic surveillance system, what would the ILPD do in that case?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I guess I'm trying to think of how— This is where it gets into the complexities of the technology in the program, but only to the extent that if you have EMRs reporting key ICD-9 codes and it's linked somehow to its originating source. I guess if that person or entity is reporting it out, then the data could go along with that report. So it may not be this directory thing, but you'd want to know like zip code information or something along that so you could tag if there's clusters of events. But that may be beyond the scope of this too.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. There's no question about the importance and significance of syndromic surveillance and the reporting of data from the provider to public health. We can look into how the ILPD could help support that as well. I'm tending to think of it right now, but perhaps after this submission the public health agency needs to follow up directly on ... and again needs to send an alert. So the actual alert might start from there, I guess, from that syndromic surveillance reporting coming to public health agencies and then public health agencies needing to generate alerts back out to not just providers that reported the data in the syndromic surveillance system, but a much larger group of providers. So they need to use the ILPD to identify them, or something like that. We can certainly look into linking the bidirectional exchange there for public health reporting.

The next part of the discussion we really want to focus on some of the other elements ... of the ILPDs and ... outcome of the features, the content, etc. So this slide is a transition slide, but it's an important slide because it really highlights the various what we call value propositions. So we say users can identify and verify recipient information and electronic ... ILPD instead of having to contact recipients. So it simplifies the workflow and increases automation in the process. The user system no longer is responsible for maintaining its own ILPD. This is, I think, as Steve mentioned, an opportunity on the last slide and certainly in a number of other areas there is the opportunity to avoid having to maintain all these independent ILPDs. The opportunity to share some of the costs and some of the functionality and improving the quality of the information, the comprehensiveness of the ILPDs, etc. So that's another value proposition of ILPDs. Also, the user system can determine what information exchange capabilities are available at each recipient, so this would help enrich the content transfer of information and enable more automation, reduce errors in the exchanges.

Then finally, users can potentially query ILPDs for additional information. Again we're trying to highlight a few of the other aspects or opportunities of ILPD's administrative facts, license information, degree information, again, not to replace any of the credentialing or anything like that, but to aid in verifying and confirming identities and determining that this is the right provider that I want to send data to. Those are some of the value propositions. Any comments or reactions to that, or any other value propositions people can add to in helping document the reason why ILPDs will be valuable?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I like that we're strongly focusing on Meaningful Use and exchange, but I think as states particularly are looking to salvage this functionality, a big part of the value proposition is how this can support other activities like assembling and appropriately attributing data for quality reporting or even functions that really aren't related to exchange. So I don't think we have to pull that into our scope, but find a way to acknowledge it as part of what's driving the actions at the state level.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, could you say a little more about, for example, the quality reporting?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
You just might need to, if you want to attribute data that's coming from different sources to providers for the purposes of knowing across your different types of care, for instance, what your readmission rates are, I don't know, you'd need a more definitive way to identify the providers in question. So a directory, if

properly structured, could serve a purpose like that. When we've heard from states, particularly like Wisconsin that's really been far along in developing its individual level directory, it's really thinking of this as a modular service that can serve a lot of needs. Again, I don't want to complicate our job of defining from an exchange standpoint what's needed, but I think we do need to acknowledge that there might be a much broader set of purposes or uses for this beyond what we had in mind.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Good point. Yes, we can certainly make that sort of an overarching statement at the beginning, if you will, of the description of ILPDs, that while the primary value could come from the support of meaningful use and information exchanges, that there are certainly other significant values that can be derived from the use of ILPDs beyond exchanges. We can mention some of the things that you mentioned about quality reporting and things like that. Yes. Other comments? Other thoughts about the value propositions?

Okay, well, let's go then to the next few slides. The next slide talks about some of the characteristics. At the end, if you recall with the entity level provider directory we had a series of recommendations about users, end users, and about the content following our overall provider directory framework, and so we started to document those of course here as well for the ILPDs. So we'll start by saying, who should be listed in these ILPDs? Primarily, this will be the individual healthcare providers, for example, physicians, clinicians, dentists, or others, and we can reference a legal definition of individual healthcare providers in the definition provided in HIPAA or the definition available from Meaningful Use or some other definitions that usually tend to be very consistent, or somewhat consistent in identifying who individual healthcare providers are. But that ... we started by identifying as who should be listed. Any others beyond individual healthcare providers that people think we should consider including in the listing?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Well, only to the extent you discern between individuals as in individual clinician providers, versus institutional providers. So it may be more relevant if you're talking about acute care, or initially relevant, but there will be a team of clinicians who need access to information. So it may be that you want to be able to go to St. Joseph Hospital or this particular location, or you may want to go to the University of Kentucky Hospital, into their EMR. So you may want to include entity level providers, I guess. That's probably blurring a different concept, but I think you get my point, I hope.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
In the entity level provider directory, we have the listing of the entities and we define them, I guess, in the description of the entity level provider directory as the entity is a clinic, a hospital, different settings. In here this individual level, the intent was really to list or to have a white pages, if you will, in the true sense of white pages, of the individual rather than a business or an entity. Inside the record, if you will, of that individual there will be a set of fields or characteristics. One of them would be the location information, so that there is a way to derive from the individual the location.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
That's helpful, except that, and perhaps the concept I'm raising is not for this particular slide and certainly maybe not for ILPDs, but here's a real scenario that happens all the time. The patient lives out in a rural community 50 minutes outside of the big city and the primary care doctor refers the patient into the big city, so go to the ER to get your evaluation and wants to send their records along. They don't know which doctor or doctors or caregivers will see that patient. They just know that they want to send a CCD to St. Joe Hospital so that when the patient arrives there the information is in their EMR and available in the institution's EMR for whomever needs to see it. That's one scenario that I'm sure happens across the country on a very regular basis. Now there's a blurring, I guess, in that scenario of individual versus entity.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
We're talking about an entity, but on the other hand they won't know which doctor or clinician is going to see the patient, so they can't push that information to an individual clinician. They need to push it to an entity's EMR.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So with the ELPD (the entity level provider directory), the one used to identify that, for example, I know that I want to send the patient to the doctors in Kaiser but I don't know which doctor specifically. So the entity level provider directory will provide the Kaiser entry so that the submitter of that data can point to where to send that to Kaiser, not to a particular doctor in Kaiser, but to Kaiser. So the entity level provider directory will support that in the way we have been thinking, but then if there is a need to identify the individual then the individual level provider directory would be the one to support. Again, there's going to be connections between the two directories, that's something we'll be making clear that's one of the features of the two. But I think what we were trying to distinguish was if you're sending something to an entity then you can identify the work you send to that entity from the ELPD, the entity level provider directory. But if you want to direct something to a specific individual within a location then the ILPD would be the one supporting that.

Hunt Blair – OVHA – Deputy Director
I wonder if the situation of wanting to send—picking up on the last examples, sending a CCD to a nursing home, say, or a home health agency, are we envisioning—and I know at the moment that most nursing homes and home health agencies aren't capable of receiving a CCD, but let's suspend that for a moment. Are we envisioning that every nursing home and home health agency in the country would ultimately be in the entity level directory?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, the answer is yes. This is not just clinic to hospital, this is every healthcare entity .... Well, in our entity level recommendations we describe those and define them and give examples of course, including examples like long term care, nursing home, etc.

Hunt Blair – OVHA – Deputy Director
Okay, I just wanted to clarify that. Thanks.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. So then the what data about the individuals we would include in this provider directory, this is what we have thought in terms of the categories of information. So the basic demographic about what we call "demographics" and identification information about the individual, so the main identifiers, like the MPI, the VA numbers, state license numbers, and other identifiers. Then there's the practice and credentials information, so the provider type based on categorization of types, specialties, categories, degrees, and then license types, so state license, the source of the license, the jurisdiction, reference information, some more information about those licenses. Then a category of information about the location, which is a very critical part, so practice sites, name, addresses, so the contact information. Then the site links to the ELPD itself.

Then the final category is security credentials information, so basically information about the security credentials. I guess here I wanted to clarify because I heard earlier we've been talking about, of course, security credentials at the entity level when we talk about the entity level provider directory. To some extent we, at least I was thinking that there was going to be some level of security credentials expected from individual providers. But, again, we might not need to get to that level, but I just wanted to ask... what people think about that, so, ... the categories of various types of information that we would need listings about a provider and then we can talk about more details of security credentials, whether that's something needed at the individual level or not.

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)

I'm thinking that maybe this is a good time, we conducted a survey about two months ago in conjunction with eHI trying to get at exactly what you're getting at here, which is what data should be included in an HIE directory. I shared last week, I think, Kory, if you're on the phone, the results of that. We went out to, I think, 76 HIE folks throughout the country, we used eHI's contact list, and the results are ready so I'd love to get them shared with the group. As I said, I sent them to Kory last week and if you think you want to see them, if we can get them out that would be great. It gets at what people are finding. All of the items that are identified here are absolutely minimum straw person data sets, but there are additional things that have shown up and it's kind of interesting to see what people are looking at. So I'll be happy to get that out.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That would be terrific.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Kory can answer too, we would be delighted to get that out. Also when folks look at it, if people think it would be helpful to have a spot on the agenda for our next taskforce for you to discuss those results, we can do that as well.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That would be great. Can I assume you'll get it out, Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes, Kory or I will get it out today; we can get it out later today.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Terrific, thank you.

M
Walter, I'd like to, on another point, when we get that data, which will be helpful, if we could come back and discuss this again a little bit just to understand what needs to be in there versus what— Physician identity theft is a real problem. We publish all these numbers and stuff everywhere, but we've held a position to protect them very carefully and then they're on CMS' Web site, so just to discuss what's necessary and useful versus what is extraneous perhaps.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, absolutely.

Paul Egerman – Software Entrepreneur
I agree with that point. I also wanted to comment on the security credentials part, which you mentioned, Walter. So far we don't have a concept for information exchange for having individual security credentials, and even if we did you'd have to be careful about this identity theft business. So that's one that I would—somehow on my screen I'd put in a slightly, I'd like gray it out or something. In other words, it's not in a minimal data set to be included, at least so far.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think you're, Paul, hopefully linking it back to the discussion we had before about the tiger team recommendations, the way direct is structured, etc., right?

Paul Egerman – Software Entrepreneur
Well, it's hard for me to link it to how direct is structured, because direct is like an independent project and I'm not involved with that. So that's a good question. If you want to link it to direct I think we've got to get Arien or somebody to help us do that, because I'm not the right person to do that.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Okay, so I think I'm hearing, and this is an excellent point, I think we have to have a ... discussion about what the minimum data that's needed and then how to appropriately balance the risks and concerns around certainly physician identity theft. So I think what we can do, particularly for this topic, is we would use part of our next call really to talk about this in more detail and take advantage of the information that we will be receiving from the survey that was conducted. I think that will be very helpful to have. But I think generally we're saying that certainly there is a minimum data set that needs to be maintained in this ILPDs about each individual and that the degree to which there's granularity in those will depend on primarily I guess minimum functionality that is needed. In other words, why do we need to capture specific data elements if it's not going to support minimum functionality of identifying location, for example, and things like that.

There's also, of course, availability of some of this information already out there, so some of the data already exists. The MPI is a public number. State license numbers are generally available. But there are some others with much more sensitive information that might not be appropriate to include in these type of provider directories. So I think with that, we can move to the next slide and talk about the functionality itself. But again we'll reserve more time at the next call to talk about the details of the data elements.

With respect to the functional capabilities of ILPDs, these were the five that we came across, again, building from the description of what the functionalities are for ELPDs, for the entity level directories. So we started with the concept of supporting directed exchanges, both send and receive, as well as the query or retrieve, which is again consistent with the ELPD functional capabilities that we describe here. The second one is provide basic discoverability of the individual provider, so who's the right doctor, and the individual provider's practice location, so what the appropriate location, the right location for that .... Then also provide basic discoverability of the individual providers with security credentials, and here again I think we'll need to decide as to whether this is going to be needed to be supported by the ILPD, the individual level security credentials, if we get to that point.

There's a functional capability of linking too and interacting with the ELPD for providing the basic information regarding the exchange capabilities of the entity where the individual provider practices. So once we know who's the right provider and what is the right location for that right provider to send messages, we can pull out from the ELPD the information exchange capabilities of that location. Then we also mentioned a mechanism for individuals listed in the ILPD or their delegated representatives, to maintain the correct or updated information that's administrative functionality. Those are the functional capabilities we identified and listed here for ILPDs. Any reactions or comments to this?

Again, the one that we'll have to think more about too, I guess, is going to be this individual provider security credentials discoverability part, that's something to think about, whether that's an element to be included in the ILPD because depending on whether that is a functional capability then the content itself will need to be inclusive of that. If we are concerned about having that information be able to be discovered through ILPDs then we'll need to ... it out, as Paul said, or block it.

M
Yes, Walter, the way I look at it, there are two different issues with individual security credentials. One is just what is the functionality there in terms of what is required? The second one is whatever the functionality is do we want to have that be discoverable, those ...? You can decide to have individual credentials, but you might decide you don't want that discoverable through the directory.

M
... directory ....

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, we'll— Go ahead.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary

I don't know if you can hear me. But back to an earlier point that Paul made, there may be a need to either here or elsewhere describe that there may be a need to have an association with privacy, either access or some sort of notion of .... I don't know exactly where it fits, but I do think we need to make some statements about this in probably the functional capability on how the ILPD would interact with a patient's ... providers.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Jonah, are you talking about the providers that already keep their information private?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
No, I think it's more about the patient. I don't know exactly how you would do it, but in the pull scenario, as you mentioned, I think we do need to make an association between that scenario and the ILPD and privacy ... of the individual patients.

M
I think you can do it in a simple way. You can simply say, "subject to fulfilling all privacy requirements the following will occur."

M
I was just looking for it to be acknowledged someplace.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think I understood it that way too. That it was more ensuring that in the assumptions. In the understanding of the news of the ILPD entities we'll be expected to operate and comply with federal and state and other privacy requirements and patient consent choices as information is being exchanged, or is going to be exchanged or is going to be discovered, I guess, and the pull scenario is going to be queried and requested. So it's really being aware that if you use the ILPDs you have to comply with, of course, the federal requirements. That's what I was understanding, more than building into the ILPD's health and functional ability to recognize patient privacy preferences. Is that the way you thought about it, Paul?

Paul Egerman – Software Entrepreneur
Yes, that makes sense.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Good. Okay, so I think if we go to the next slide, I think these are some of the operating requirements and these are more questions at this point than anything else, but in terms of the content, the provision and maintenance of the content, how would that be done? There's a number of potential sources that could be used, like MPES, which contains the MPI state licensure board ... health plan directory. There's a number of sources that can be used to provide and to help maintain some of this information. So that's one of the general operating requirement questions that I'm sure we'll be getting into as we look at the next steps into this provider directory. What level of data accuracy is necessary to ensure usability of content as far as this is somewhat of a rhetorical question because in part you need the highest level of data accuracy in a number of elements. Since there will be dependency on decisions about sending or receiving data based on the information contained in the ILPD, the data accuracy will be very critical.

The best way to link individual providers to their entities and assure alignment with ... entities in the ELPD, so what is the best way to create those linkages between the individual provider and the entity. How would security data use ... the advantage against some of the points that we already mentioned on the security side. But here dealing with the security of the actual and ... of the actual directory content so when the data use rights for accessing and using the ILPD. Is there a need to link the ILPD to other tools that map patients to the providers, so that people are able to do things like verify that an identified provider is the right one. So what are other possible tools that can help map providers and patients and allow the identification of ... providers?

These are some of the operating requirements and questions that we have. I know we're in the last nine minutes of our call today, and I think this will be really the topic of our next call. We just wanted to put out this set of questions as we begin to look at some of the functional characteristics of the operation of the ELPD. So any comments or reactions to this slide on operating requirements?

Okay, so I think what I'm going to do, I think we have had a very, very good discussion on the use cases that describe the usability of these ILPDs and we're going to be refining and providing more details about them with some additional examples. We had a very good conversation, a discussion about the users and the uses and the functionality. The content, we started the discussion on the content part, and I think what we wanted to do in our next call, which again I think is January 24th, is going to be to focus our attention on the operating requirements— Well, first of all, I think what we're going to do is come back. We're going to refine use cases and refine description of the uses and users and content and functionality. Then focus our attention on business models that we would be recommending and the policy recommendations that we would make, so that we can finalize those at the next call on the 24th and then present those to the full Information Exchange Workgroup for their approval.

I think that's basically it. Like I said, is there a next slide? Oh yes, next steps. I guess this is what I was getting to. The next meeting we will present these recommendations. So I just mentioned all those things that we will be focusing our attention on those, we'll refine the materials from this meeting today and then add more description of the business models and the policy issues for discussion and then moving it to the Information Exchange Workgroup on the 28th of January. Is there a next slide? Oh yes, I think we wanted to include, and people have asked that so we wanted to include a copy of the glossary that we developed for the entity level provider directory, so that's what the next slides are that we're not going to cover. In these materials, we included the glossary that we developed for provider directories as a reference document.

Okay, so I think with that, are there any final comments, Jonah, any final thoughts?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
No, thank you. I really appreciate your taking over today.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thank you, everyone, for participating and thanks to all our staff. The members of our ONC team I think we had a wonderful exchange in preparing this material, so thank you to the team and to Kory and to Claudia and everybody else for contributing and developing this. Any final thoughts or comments from any member of the taskforce before we go to the public comments? Okay, hearing none, Judy, I'm going to turn it to you for you to open it for public comments.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you please invite the public to make comments if they wish.

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, operator. Thank you, everybody.

M
Thank you.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Thank you very much, again. We'll be in touch and come back together on the 24th. Thank you. Have a great rest of the week.

Public Comment Received During the Meeting

1. Is there a use case for the using ILPD to support lab tests in a pull scenario? Governance and control - will this allow a central authority to stop the exchange of information for an individual provider and who will be making these decisions? Add the functionality of (expiration date of data) or methods for periodic verification - users need to understand the currency of the data. There is a need for wholesale transfer of patient links from one provider to another provider and other situations where patients and providers move, retire or die.

2. Governance and control - will this allow a central authority to stop the exchange of information for an individual provider?

3. Steve Witter: Someone indicated that the primary purpose of the ILPD would be to determine which entity to route the data to (absolutely essential) and therefore the address/location of a particular clinic is not important. That is not a valid assumption. What if the patient is with the doctor trying to make a referral and determining where the patient would be able/willing to go for the referral. As an example then if the referral goes to say Atrius Health in Massachusetts with over 30 offices… the entity level data for routing is known, however to complete the referral the physical location is still essential for the patient and completion of the referral… It would appear then that there needs to be a place and process where this data stored/located and maintained/verified.

4. Steve Witter: A couple of Issues, most current EMR's depend on an internal provider directory to identify the PCP or specialist that information needs to be routed to / pulled from. If that data is not in the local EMR – then the EMR functionality needs to be changed to work off the HIE ILPD (or they need to be synched) – this is not an inconsequential task… Also the EMR provider directory today also interfaces to other internal systems for billing and other functions… this functionality will still need to be supported.

5. Steve Witter: In both the push and pull use case scenarios; there is an assumption that Individual Level Provider Directory data is not stored at the local hospital/clinic/lab. Additionally there is an assumption that there are multiple locations at the HIE level ILPD…but there is no decision made about which of the Individual provider locations are valid. This thus assumes that the clinician knows something that allows them to determine which address/location is valid for a particular encounter/service/consultation/referral/order etc. (this may not be a valid assumption). Once the correct location in the ILPD is determined then the ILPD has a link to the Entity Level Provider directory.